FOR OHF USE

LL I

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042366

Facility Name: MAPLE RIDGE CARE CENTRE

Address: 2202 N. KICKAPOO (Number) LINCOLN (City) 62656 (Zip Code)

County: LOGAN

Telephone Number: (217) 735-1538 **Fax #** (217) 735-4818

IDPA ID Number: 36-4109662

Date of Initial License for Current Owners: 11/01/96

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name BOB KAGDA Telephone Number: (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2000 to 12/31/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) SHAEL BELLOWS
(Title) MANAGEMENT CONSULTANT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA/PARTNER
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1
(Telephone) (847) 675-3585 Fax (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

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Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	95	Skilled (SNF)	95	34,770	1
2		Skilled Pediatric (SNF/PED)			2
3	25	Intermediate (ICF)	25	9,150	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,920	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,312	611	4,946	7,869	8
9	SNF/PED					9
10	ICF	25,509	6,642	2,602	34,753	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,821	7,253	7,548	42,622	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4 97.04%

D. How many bed-hold days during this year were paid by Public Aid? 404 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/01/96

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/01/96 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 20 and days of care provided 2393

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 **Report Period Beginning:** 01/01/2000 **Ending:** 12/31/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	162,579	21,896	10,394	194,869		194,869	(1,263)	193,606			1
2	Food Purchase		156,193		156,193		156,193	(809)	155,384			2
3	Housekeeping	148,892	15,954	0	164,846		164,846	466	165,312			3
4	Laundry	3,900	20,427	75	24,402		24,402	(402)	24,000			4
5	Heat and Other Utilities			120,837	120,837		120,837	0	120,837			5
6	Maintenance	43,225	14,793	12,547	70,565		70,565	6,476	77,041			6
7	Other (specify):*			7,863	7,863		7,863	0	7,863			7
8	**TOTAL General Services**	358,596	229,263	151,716	739,575		739,575	4,468	744,043			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000	0	18,000			9
10	Nursing and Medical Records	1,142,823	56,114	5,879	1,204,816		1,204,816	13,400	1,218,216			10
10a	Therapy	0		7,157	7,157		7,157	0	7,157			10a
11	Activities	97,317	4,107	2,600	104,024		104,024	560	104,584			11
12	Social Services	0		2,600	2,600		2,600	0	2,600			12
13	Nurse Aide Training			4,400	4,400		4,400	0	4,400			13
14	Program Transportation			0				0				14
15	Other (specify):*							0				15
16	**TOTAL Health Care and Progra**	1,240,140	60,221	40,636	1,340,997		1,340,997	13,960	1,354,957			16
	C. General Administration											
17	Administrative	66,256		338,797	405,053		405,053	(324,775)	80,278			17
18	Directors Fees			0				0				18
19	Professional Services			165,318	165,318		165,318	2,283	167,601			19
20	Dues, Fees, Subscriptions & Promotions			32,405	32,405		32,405	(21,862)	10,543			20
21	Clerical & General Office Expense	100,662	25,196	72,861	198,719		198,719	81,797	280,516			21
22	Employee Benefits & Payroll Taxes			331,766	331,766		331,766	0	331,766			22
23	Inservice Training & Education			10,560	10,560		10,560	0	10,560			23
24	Travel and Seminar			2,751	2,751		2,751	7,967	10,718			24
25	Other Admin. Staff Transportation			18,927	18,927		18,927	0	18,927			25
26	Insurance-Prop.Liab.Malpractice			50,925	50,925		50,925	3,797	54,722			26
27	Other (specify):*			197,250	197,250		197,250	(197,250)				27
28	**TOTAL General Administration**	166,918	25,196	1,221,560	1,413,674		1,413,674	(448,043)	965,631			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,765,654	314,680	1,413,912	3,494,246		3,494,246	(429,615)	3,064,631			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			38,464	38,464		38,464	103,860	142,324			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest			147,202	147,202		147,202	105,314	252,516			32
33	Real Estate Taxes			27,873	27,873		27,873	0	27,873			33
34	Rent-Facility & Grounds			312,000	312,000		312,000	(301,617)	10,383			34
35	Rent-Equipment & Vehicles			28,481	28,481		28,481	5,261	33,742			35
36	Other (specify):* STORAGE			900	900		900	0	900			36
37	TOTAL Ownership			554,920	554,920		554,920	(87,182)	467,738			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers		62,412	136,322	198,734		198,734	0	198,734			39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			65,880	65,880		65,880	0	65,880			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers		62,412	202,202	264,614		264,614		264,614			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,765,654	377,092	2,171,034	4,313,780	0	4,313,780	(516,797)	3,796,983			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2000 Ending: 2/31/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals		2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients		10		7
8	Laundry for Non-Patients		4		8
9	Non-Straightline Depreciation	(20,920)	30		9
10	Interest and Other Investment Income	(41,004)	32		10
11	Discounts, Allowances, Rebates & Refunds		2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(809)	2		13
14	Non-Care Related Interest	(44,298)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	0	21		18
19	Entertainment	0	20		19
20	Contributions	(3,412)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers	(1,309)	19		22
23	Malpractice Insurance for Individuals		26		23
24	Bad Debt	(197,250)	27		24
25	Fund Raising, Advertising and Promotional	(15,866)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees		13		27
28	Yellow Page Advertising	(3,763)	20		28
29	Other-Attach Schedule DEFERRED MAINT XIX-H	6,476	6		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (322,155)		$	30

OHF USE ONLY								
48		49		50		51	52	

B. If there are expenses experienced by the facility which do not appear in th general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(196,660)	G 6 & 6A	34
35	Other- Attach Schedule	2,018	PG 5A	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (194,642)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (516,797)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Print Preview

ıe

Detail lines 29 and 35 of Page 5 starting in B44 DO NOT DRAG AND DROP CELLS.

The amounts in columns F will transfer to the Adj. Summary column automatically.

The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.

1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

Print Other

STATE OF ILLINOIS — **Page 5A**

Facility Name MAPLE RIDGE CARE CENTRE

IDH 0042366

Report Period Beginning: 01/01/2000

Ending: 12/31/2000

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V	Adj. Summary
	The information listed in B13 thru G43 is from Page 5.			**Line 1**	(1,283)
1	**Day Care**	0	0	**Line 2**	(809)
2	**Other Care for Outpatients**	0	0	**Line 3**	466
3	**Governmental Sponsored Special Programs**	0	0	**Line 4**	(402)
4	**Non-Patient Meals**	0	2	**Line 5**	0
5	**Telephone, TV & Radio in Resident Rooms**	0	0	**Line 6**	6,476
6	**Rented Facility Space**	0	34	**Line 7**	0
7	**Sale of Supplies to Non-Patients**	0	10	**Line 8**	5,460
8	**Laundry for Non-Patients**	0	4	**Line 9**	0
9	**Non-Straightline Depreciation**	(20,920)	30	**Line 10**	7,000
10	**Interest and Other Investment Income**	(41,004)	32	**Line 10a**	0
11	**Discounts, Allowances, Rebates & Refunds**	0	2	**Line 11**	500
12	**Non-Working Officer's or Owner's Salary**	0	0	**Line 12**	0
13	**Sales Tax**	(809)	2	**Line 13**	0
14	**Non-Care Related Interest**	(44,298)	32	**Line 14**	0
15	**Non-Care Related Owner's Transactions**	0	0	**Line 15**	0
16	**Personal Expenses (Including Transportation)**	0	25	**Line 16**	7,783
17	**Non-Care Related Fees**	0	20	**Line 17**	1,783
18	**Fines and Penalties**	0	21	**Line 18**	0
19	**Entertainment**	0	20	**Line 19**	(1,709)
20	**Contributions**	(3,412)	20	**Line 20**	(23,041)
21	**Owner or Key-Man Insurance**	0	22	**Line 21**	(8,772)
22	**Special Legal Fees & Legal Retainers**	(1,309)	19	**Line 22**	0
23	**Malpractice Insurance for Individuals**	0	26	**Line 23**	0
24	**Bad Debt**	(197,250)	27	**Line 24**	0
25	**Fund Raising, Advertising and Promotional**	(15,866)	20	**Line 25**	0
26	**Income & IL Personal Property Replacement**	0	0	**Line 26**	0
27	**Nurse Aide Training for Non-Employees**	0	13	**Line 27**	(197,250)
28	**Yellow Page Advertising**	(3,763)	20	**Line 28**	(225,504)
29	**Non-Paid Workers**	0	0	**Line 29**	(213,949)
30	**Donated Goods**	0	0	**Line 30**	(29,928)
31	**Amortization Expense**	0	0	**Line 31**	0
32	PAGE 5 - LINE 35 VACATION ACCRUAL	(1,283)	1	**Line 32**	(85,380)
33	PAGE 5 - LINE 35 VACATION ACCRUAL	466	3	**Line 33**	0
34	PAGE 5 - LINE 35 VACATION ACCRUAL	(402)	4	**Line 34**	0
35	PAGE 5 - LINE 35 VACATION ACCRUAL	0	6	**Line 35**	0
36	PAGE 5 - LINE 35 VACATION ACCRUAL	7,001	10	**Line 36**	0
37	PAGE 5 - LINE 35 VACATION ACCRUAL	560	17	**Line 37**	(106,224)
38	PAGE 5 - LINE 35 VACATION ACCRUAL	1,783	17	**Line 38**	0
39	PAGE 5 - LINE 35 VACATION ACCRUAL	(6,127)	21	**Line 39**	0
40	PAGE 5 - LINE 29 DEFERRED MAINTENANCE	6,476	6	**Line 40**	0
41				**Line 41**	0
42				**Line 42**	0
43				**Line 43**	0
44				**Line 44**	0
45				**Line 45**	(320,137)

Reference 1 Reference 2 Reference 3 Reference 4 Reference 5 Reference 6 Reference 7 Reference 9 Reference 10 Reference 10a Reference 11 Reference 12 Reference 13 Reference 14 Reference 15 Reference 17 Reference 18 Reference 19 Reference 20 Reference 21 Reference 22 Reference 23 Reference 24 Reference 25 Reference 26 Reference 27 Reference 30 Reference 31 Reference 32 Reference 33 Reference 34 Reference 35 Reference 36 Reference 38 Reference 39 Reference 40 Reference 41 Reference 42 Reference 43

STATE OF ILLINOIS

Summary A

Facility Name & ID Numb MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(1,263)	0	0	0	0	0	0	0	0	0	0	(1,263)	1
2	Food Purchase	(809)	0	0	0	0	0	0	0	0	0	0	(809)	2
3	Housekeeping	466	0	0	0	0	0	0	0	0	0	0	466	3
4	Laundry	(402)	0	0	0	0	0	0	0	0	0	0	(402)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	6,476	0	0	0	0	0	0	0	0	0	0	6,476	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	4,468	0	0	0	0	0	0	0	0	0	0	4,468	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	7,001	6,399	0	0	0	0	0	0	0	0	0	13,400	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	560	0	0	0	0	0	0	0	0	0	0	560	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Program**	7,561	6,399	0	0	0	0	0	0	0	0	0	13,960	16
	C. General Administration													
17	Administrative	1,783	(326,558)	0	0	0	0	0	0	0	0	0	(324,775)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,309)	3,192	400	0	0	0	0	0	0	0	0	2,283	19
20	Fees, Subscriptions & Promotions	(23,041)	1,179	0	0	0	0	0	0	0	0	0	(21,862)	20
21	Clerical & General Office Expenses	(6,127)	87,924	0	0	0	0	0	0	0	0	0	81,797	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	7,967	0	0	0	0	0	0	0	0	0	7,967	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	3,797	0	0	0	0	0	0	0	0	0	3,797	26
27	Other (specify):*	(197,250)	0	0	0	0	0	0	0	0	0	0	(197,250)	27
28	**TOTAL General Administration**	(225,944)	(222,499)	400	0	0	0	0	0	0	0	0	(448,043)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(213,915)	(216,100)	400	0	0	0	0	0	0	0	0	(429,615)	29

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Numb: MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary B

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(20,920)	6,741	118,039	0	0	0	0	0	0	0	0	103,860	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(85,302)	0	190,616	0	0	0	0	0	0	0	0	105,314	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	10,383	(312,000)	0	0	0	0	0	0	0	0	(301,617)	34
35	Rent-Equipment & Vehicles	0	5,261	0	0	0	0	0	0	0	0	0	5,261	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(106,222)	22,385	(3,345)	0	0	0	0	0	0	0	0	(87,182)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Cent	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(320,137)	(193,715)	(2,945)	0	0	0	0	0	0	0	0	(516,797)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Numbe MAPLE RIDGE CARE CENTRI # 0042266 Report Period Beginning 01/01/2000 Ending 12/31/2000

Show Pgs 6A thru 6 | Show Pgs 6E thru 6I | Hide Pgs 6A thru 6I

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST OF		SEE ATTACHED LIST OF RELATED		FIRST HEALTH CARE ASSOCIATES, I		MANAGEMENT
OWNERS		NURSING HOMES		DIVISION OF FHC ENTERPRISE, INC.)		CONSULTANT
					ROSEMONT, IL	
				LANDMARK PROPERTIES		
					ROSEMONT, IL	REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6
1	V	10 NURSING	$	FHC ENTERPRISES INC		$ 6,399	$ 6,399	1	6399
2	V	17 ADMINISTRATIVE	220,797	" " MJC BELLOWS OWNS 95% OF THIS FACILITY		12,239	(328,598)	2	-326558
3	V	19 PROFESSIONAL FEES		" " AND 100% OF FHC ENTERPRISE		3,192	3,192	3	3192
4	V	20 DUES & SUBSCRIPTIONS		" "		1,179	1,179	4	1179
5	V	21 CLERICAL		" "		87,924	87,924	5	87924
6	V	24 TRAVEL		" "		7,967	7,967	6	7967
7	V	26 INSURANCE		" "		3,797	3,797	7	3797
8	V	28 DEPRECIATION		" "		6,741	6,741	8	6741
9	V	34 RENT		" "		10,383	10,383	9	10383
10	V	35 RENT/EQUIPMENT & VEH		" "		5,261	5,261	10	5261
11	V							11	
12	V							12	
13	V							13	
14	Total		$ 220,797			$ 145,082	$ * (193,715)	14	

* Total must agree with the amount recorded on line 34 of Schedule V

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

Print Preview

1. Enter the information on pages 5 and 5A.
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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line
1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43

Print Page 6A

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6A
15	V	19	PROFESSIONAL FEES	$	LANDMARK PROPERTIES		$ 400	$ 400	15	400
16	V	30	DEPRECIATION - SL		" "		111,504	111,504	16	111504
17	V	30	DEPRECIATION - SL		" "		6,535	6,535	17	6535
18	V	32	INTEREST MORTGAGE		" "		186,117	186,117	18	186117
19	V	32	AMORTIZATION - MTG COST		" "		4,499	4,499	19	4499
20	V	34	RENT	312,000	" "			(312,000)	20	-312000
21	V								21	
22	V								22	
23	V								23	
24	V								24	
25	V								25	
26	V								26	
27	V								27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$ 312,000			$ 309,055	$ * (2,945)	39	

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
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5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6B

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STATE OF ILLINOIS

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6B

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
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Print Page 6C

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6C

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
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Print Page 6D

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STATE OF ILLINOIS

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6D

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
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5. The adjustments entered on this page will automatically transfer to the summary pages.

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	RELATED PARTY - FHC ENTERPRISES INC.								$		1
2	SHAEL BELLOWS	MNGMT CNSLT.	ADMIN.	95.00	SEE ATTACHED	1.98	5.77	SALARY	12,239	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 12,239		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REI

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Print Preview

the name(s)
PORTS.

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8D | Show Pgs 8E thru 8I | Hide Pgs 8A thru 8I

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: FHC ENTERPRISES INC.
Street Address: 10700 W. HIGGINS ROAD, STE. 300
City / State / Zip Code: ROSEMONT, IL 60018
Phone Number: (847) 296-9625
Fax Number: (847) 298-0824

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	PATIENT DAYS	480,456	10	$ 72,138	$ 72,138	42,622	$ 6,399	1
2	17	ADMINISTRATIVE	PATIENT DAYS	480,456	10	137,966	137,966	42,622	12,239	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	480,456	10	35,987		42,622	3,192	3
4	20	DUES AND SUBSCRIPTION	PATIENT DAYS	480,456	10	13,291		42,622	1,179	4
5	21	CLERICAL	PATIENT DAYS	480,456	10	742,182	614,607	42,622	65,840	5
6	21	CLERICAL	HOURS	1	1	22,084	22,084	1	22,084	6
7	24	TRAVEL	PATIENT DAYS	480,456	10	89,811		42,622	7,967	7
8	26	INSURANCE	PATIENT DAYS	480,456	10	42,804		42,622	3,797	8
9	30	DEPRECIATION	PATIENT DAYS	480,456	10	75,987		42,622	6,741	9
10	34	RENT	PATIENT DAYS	480,456	10	117,045		42,622	10,383	10
11	35	RENT-EQUIPMENT & VEH	PATIENT DAYS	480,456	10	59,305		42,622	5,261	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,408,600	$ 846,795		$ 145,082	25

Print Preview

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Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

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STATE OF ILLINOIS

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

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STATE OF ILLINOIS

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

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Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	RELATED PARTY - LANDMARK PROPERTIES						$	$			$	1
2	AMERICAN NATIONAL BANK		X	MORTGAGE	VARIES	11/96	2,980,000	2,215,400		0.0725	186,117	2
3	LOAN COST			LOAN COST							4,499	3
4												4
5												5
	Working Capital											
6	AMERICAN NATIONAL BANK		X	WORKING CAPITAL	VARIES		500,000	300,000	DEMAND	PRIME +	34,196	6
7												7
8	RELATED FACILITIES	X		WORKING CAPITAL	DEMAND		783,000	989,000	DEMAND	PRIME +	68,708	8
9	TOTAL Facility Related						$ 4,263,000	$ 3,504,400			$ 293,520	9
	B. Non-Facility Related*											
10	LANDMARK PROPERTIE	X		WORKING CAPITAL	DEMAND		455,000	455,000	DEMAND	PRIME +	44,298	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 455,000	$ 455,000			$ 44,298	14
15	TOTALS (line 9+line14)						$ 4,718,000	$ 3,959,400			$ 337,818	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Print Preview

Facility Name & ID Numbe MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	30,062	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	29,063	2
3. Under or (over) accrual (line 2 minus line 1).	$	(999)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	28,872	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	27,873	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	0	8
	1996	29,035	9
	1997	29,260	10
	1998	29,229	11
	1999	29,063	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 1999 TAX YEAR.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATIC	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Print Preview

Facility Name & ID Numb MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 34,774 B. General Construction Type: Exterior MASONRY Frame STEEL/WOOD Number of Stories

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	170,750	1996	$ 148,352	1
2					2
3	TOTALS	170,750		$ 148,352	3

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B | Show Pgs 12C and 12D | Hide Pgs 12A thru 12D

STATE OF ILLINOIS

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120		1996		$ 2,891,648	$ 27,429	27.5	$ 105,151	$ 77,722	$ 442,510	4
5			1997		15,792	574	27.5	574		2,118	5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	RELATED PARY - LANDMARK PROPERTIES										9
10	DINING ROOM REMODELING			1997	7,441	271	27.5	271		949	10
11	FENCE			1997	4,300	156	27.5	156		546	11
12	WALLCOVERING/TILE WORK			1997	11,399	415	27.5	415		1,453	12
13	INSTALLATION OF WALLCOVERING			1997	10,590	384	27.5	384		1,344	13
14	FLOOR TILES/INSTALLATION			1997	1,160	42	27.5	42		147	14
15	OUTDOOR SIGN			1997	10,880	396	27.5	396		1,383	15
16	WALLCOVERING/TILE WORK/INSTALLATION			1998	30,545	1,111	27.5	1,111		2,531	16
17	WALLCOVERING/DRYWALL/WINDOW FRAMES			1999	31,471	1,144	27.5	1,144		1,668	17
18	OUTDOOR SIGN			1999	4,190	152	27.5	152		222	18
19	PAVEMENT			1999	6,230	227	27.5	227		331	19
20	ADD LOUNGE, DINING, OFFICE & 10 BEDS			2000	24,849	452	27.5	452		452	20
21	REMODELING,OFFICE, ROOF CURB, DOORS			2000	22,801	415	27.5	415		415	21
22	WALLCOVERING, PAINTING			2000	3,683	614	3	614		614	22
23											23
24					ADJ. TO SL	77,722			(77,722)		24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 111,504		$ 111,504	$	$ 456,683	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12A

STATE OF ILLINOIS

Facility Name & ID Numbe MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12B

STATE OF ILLINOIS

Facility Name & ID Numbe MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12C

STATE OF ILLINOIS

Facility Name & ID Numbe MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12D

STATE OF ILLINOIS

Facility Name & ID Numbe MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
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	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componen Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 207,492	$ 33,811	$ 15,989	$ (17,822)	3-15 YRS	$ 58,001	37
38	Current Year Purchases	30,737	4,653	1,555	(3,098)	3-15YRS	1,555	38
39	Fully Depreciated Assets							39
40	RELATED PARTIES	131,353	13,276	13,276			87,388	40
41	TOTALS	$ 369,582	$ 51,740	$ 30,820	$ (20,920)		$ 146,944	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 163,244	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 142,324	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (20,920)	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 603,627	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Print Preview

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. _____
This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the curre
rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipm $ 18,469 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY USE	98 DODGE DURANG	$ 625.00	$ 10,012	17
18					18
19					19
20					20
21	TOTAL		$ 625.00	$ 10,012	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Print Preview

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Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY TRAINED AIDES.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [X]
- HOURS PER AIDE 80

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- HOURS PER AIDE 40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		3,719		3,719
3	Classroom Wages (a)		481		481
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		200		200
9	TOTALS	$	$ 4,400	$	$ 4,400
10	SUM OF line 9, col. 1 and 2 (e)	$ 4,400			

C. CONTRACTUAL INCOME

In the box below record the amount of income y facility received training aides from other faciliti

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	11
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	11

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Print Preview

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Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Cost	Outside Practitioner (other than consultant) Units	Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs		$		$ 60,797	$		$ 60,797	1
2	Licensed Speech and Language Development Therapist	39-3	hrs				7,008			7,008	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39-3	hrs				68,517			68,517	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39-2	# of prescrpts					47,564		47,564	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	LAB, X-RAY, I.V. THERAPY Other (specify):	39-2						14,848		14,848	13
14	TOTAL				$		$ 136,322	$ 62,412		$ 198,734	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Print Preview

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 3,098	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 39,600)	1,035,872		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	70,032		6
7	Other Prepaid Expenses	60,607		7
8	Accounts Receivable (owners or related parties)	491,593		8
9	Other(specify): ESCROW DEPOSIT	15,308		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,676,510	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	238,229		16
17	Accumulated Depreciation (book methods)	(131,814)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DEPOSITS			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 106,415	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,782,925	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 213,514	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,165		28
29	Short-Term Notes Payable	1,418,393		29
30	Accrued Salaries Payable	40,921		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,367		31
32	Accrued Real Estate Taxes(Sch.IX-B)	28,872		32
33	Accrued Interest Payable	68,741		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	MANAGEMENT FEES	326		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,788,299	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	455,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 455,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,243,299	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (460,374)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,782,925	$	48

***(See instructions.)**

Print Preview

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (416,998)	1
2	Restatements (describe):		2
3	ROUNDING	5	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (416,993)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(43,381)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (43,381)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (460,374)	24 *

*** This must agree with page 17, line 47.**

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Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,226,993	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,226,993	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thr**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	41,004	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and**	$ 41,004	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	NET VENDING COMMISSIONS	2,402	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,402	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 2**	$ 4,270,399	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 739,575	31
32	Health Care	1,340,997	32
33	General Administration	1,413,674	33
	B. Capital Expense		
34	Ownership	554,920	34
	C. Ancillary Expense		
35	Special Cost Centers	198,734	35
36	Provider Participation Fee	65,880	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,313,780	40
41	**Income before Income Taxes (line 30 minus line 40)****	(43,381)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus**	$ (43,381)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning 01/01/2000 Ending: 12/31/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,999	2,139	$ 58,263	$ 27.24	1
2	Assistant Director of Nursing	4,781	5,117	100,244	19.59	2
3	Registered Nurses	159	194	3,702	19.08	3
4	Licensed Practical Nurses	26,664	29,356	431,344	14.69	4
5	Nurse Aides & Orderlies	57,121	61,678	549,270	8.91	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	281	286	6,900	24.13	9
10	Activity Assistants	9,826	10,666	90,417	8.48	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	7,646	8,349	77,878	9.33	14
15	Cook Helpers/Assistants	12,728	13,540	84,701	6.26	15
16	Dishwashers					16
17	Maintenance Workers	2,431	2,610	43,225	16.56	17
18	Housekeepers	18,645	20,145	148,892	7.39	18
19	Laundry	619	641	3,900	6.08	19
20	Administrator	2,135	2,539	66,256	26.10	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,246	5,824	100,662	17.28	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	150,281	163,084	$ 1,765,654 *	$ 10.83	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

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B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	178	$ 10,394	1-3	35
36	Medical Director	96	18,000	9-3	36
37	Medical Records Consultant	20	1,300	10-3	37
38	Nurse Consultant	66	2,614	10-3	38
39	Pharmacist Consultant	154	1,100	10-3	39
40	Physical Therapy Consultant	90	4,549	10a-3	40
41	Occupational Therapy Consulta	35	1,739	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	17	869	10a-3	43
44	Activity Consultant	36	2,600	11-3	44
45	Social Service Consultant	36	2,600	12-3	45
46	Other(specify)				46
47	PSYCHO-SOCIAL CONSULTANT		0	10-3	47
48					48
49	TOTAL (lines 35 - 48)	728	$ 45,765		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)		$		53

0

Facility Name & ID Number MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
LISA TRUDEAU	ADMIN		15,497
MICHELLE EYRSE	ADMIN		50,759
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 66,256

B. Administrative - Other

Description	Amount
	$
FIRST HEALTHCARE - MANAGEMENT FEES	338,797
TOTAL (agree to Schedule V, line 17, col. 3)	$ 338,797
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE ATTACHED SCHEDULE		165,318
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 165,318

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 27,323
Unemployment Compensation Insurance	39,071
FICA Taxes	134,297
Employee Health Insurance	95,298
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
PENSION/PROFIT SHARING CONTRIB	3,914
EMPLOYEE BENEFITS-OTHER	27,337
EMPLOYEE PHYSICAL EXAMS	4,526
INSURANCE EXECUTIVE LIFE	0
CHICAGO HEAD TAX	0
RELATED PARTY	0
INSURANCE EXECUTIVE LIFE	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 331,766

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	639
Health Care Worker Background Chec	814
(Indicate # of checks performed)	
ADV & PROMO/MARKETING	19,629
DUES & SUBSCRIPTIONS	6,950
LICENSES & PERMITS	761
TRUST FEES, CONTRIBUTIONS,etc.	3,412
MGMT CO ALLOCATION	1,179
LESS TRUST FEES, CONTRIB, etc.	(3,412)
Less: Public Relations Expense	( )
Non-allowable advertising	(15,866)
Yellow page advertising	(3,763)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,543

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL	2,751
RELATED PARTY	7,967
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,718

**See instructions.

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Facility Name & ID Num MAPLE RIDGE CARE CENTRE # 0042366 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
		Month & Year			Amount of Expense Amortized Per Year								
	Improvement Type	Improvement Was Made	Total Cost	Useful Life	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	PAINT/DECORATI	1997	$ 1,873	3	$ 312	$ 624	$ 624	$ 313	$	$	$	$	$
2	PAINT/DECORATI	1998	8,432	3		1,405	2,811	2,811	1,405				
3	PAINT/DECORATI	1999	9,372	3			1,562	3,124	3,124	1,562			
4	PAINT/DECORATI	2000	1,366	3				228	455	455	228		
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 21,043		$ 312	$ 2,029	$ 4,997	$ 6,476	$ 4,984	$ 2,017	$ 228	$	$

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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost rep **YES**
If YES, give association name and amo **IL. HEALTHCARE ASSOC. $5280**

(3) Did the nursing home make political contributions or payments to a politica action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases **YES**
What was the average life used for new equipment added during this per **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expens and the location of this expense on Sch. V. **0** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangeme **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII) YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. **65,880**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifie in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Secti **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportatio residents? **NO** If YES, please indicate the amount of income earned from such program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and pati **5%**
d. Have vehicle usage logs been maintair **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this co been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost repo **YES**
Attach invoices and a summary of services for all architect and appraisal fees

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Facility Name & ID Number MAPLE RIDGE CARE CENTRE #0042366 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF		TOTAL
1	DIETARY			
	DIETITIAN CONSULTANT	XVIII B35	10394	
	REPAIRS & MAINTENANCE		0	
			0	10394
3	HOUSEKEEPING			
			0	
			0	0
4	LAUNDRY			
	EQUIPMENT REPAIRS & MAINTENANCE		75	
			0	75
5	HEAT & OTHER UTILITIES			
	GAS HEAT		0	
	ELECTRICITY		87955	
	WATER		32095	
	CABLE TV - LOBBY		787	
			0	120837
6	MAINTENANCE			
	GROUNDS MAINTENANCE		4330	
	PAINTING & DECORATING		1366	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		2631	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		2923	
	FIRE SERVICE		1297	
			0	
			0	
			0	12547
7	OTHER			
	SCAVENGER		7146	
	SECURITY SERVICE		717	7863
9	MEDICAL DIRECTOR			
	MEDICAL DIRECTOR FEES	XVIII B36	18000	18000

LINE		SCHED REF		TOTAL
10	NURSING			
	CONTRACT NURSING	XVIII C53	0	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		775	
	PSYCHO-SOCIAL CONSULTANT	XVIII B47	0	
	RESTORATIVE NURSING CONSULTA	XVIII B38	0	
	MEDICAL RECORDS CONSULTANT	XVIII B37	1300	
	PHARMACY CONSULTANT	XVIII B39	1100	
	UTILIZATION REVIEW FEES	XVIII B	0	
	PHYSICIANS	XVIII B	0	
	PSYCHIATRIC	XVIII B	0	
	RN CONSULTANT	XVIII B38	2614	
	DENTAL SERVICES		90	
			0	5879
10a	THERAPY			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B40	4549	
	OCCUPATIONAL THERAPY CONSUL	XVIII B41	1739	
	SPEECH THERAPY CONSULTANT	XVIII B43	869	
	RESPIRATORY CONSULTANT	XVIII B42	0	7157
11	ACTIVITIES			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B44	2600	
			0	2600
12	SOCIAL SERVICES			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULT	XVIII B45	0	
	SOCIAL WORKER	XVIII B45	2600	
			0	2600
13	NURSE AIDE TRAINING			
	NURSE AIDE TRAINING COSTS	XIII	4400	4400